TCTAP C-027

Killip4 Non ST-Elevated Myocardial Infarction with Chronic Total Occlusion and Left Main Trunk Disease

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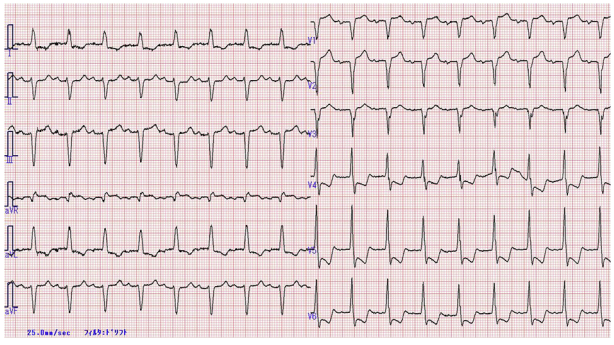
[CLINICAL INFORMATION]

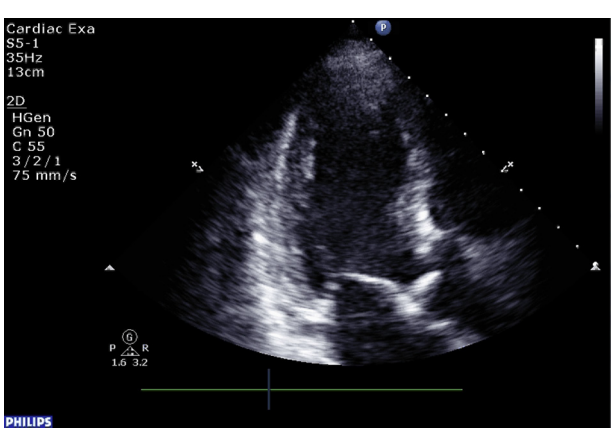
Patient initials or identifier number. O.S.

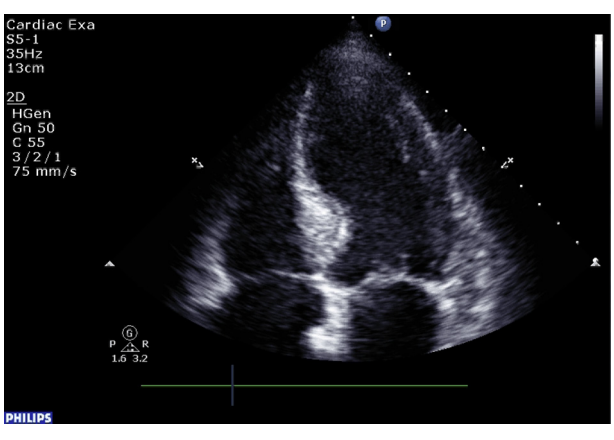
Relevant clinical history and physical exam. A case was 89 y.o. male. His past history was hypertension, dyslipidemia and non-treated abdominal aortic aneurysm.

He complained vomiting due to hypotension, so consulted a home doctor. He was diagnosed as congestive heart failure then was transferred to our hospital.

Cardiac echo and ECG showed non-ST elevated myocardial infarction (NSTEMI) then emergent coronary angiogram was performed.

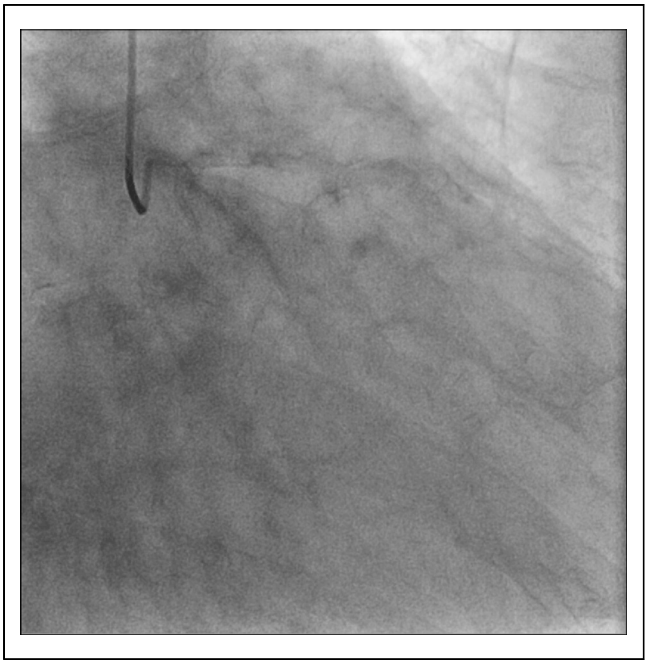


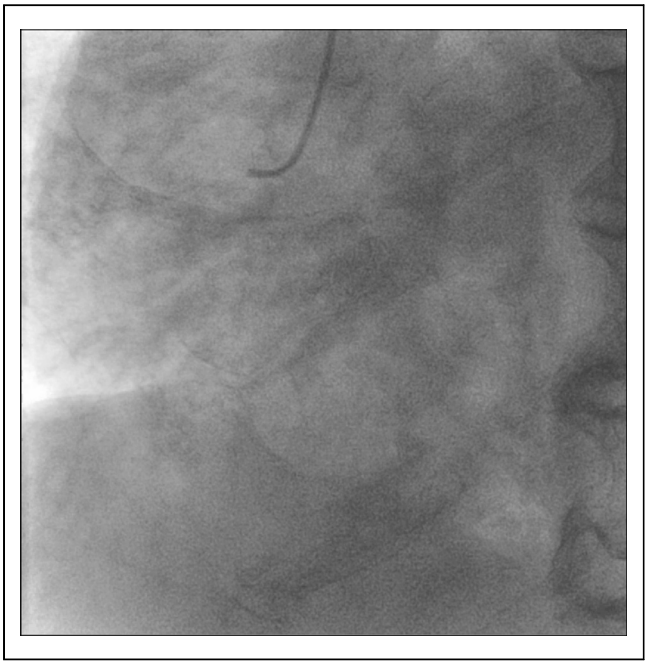




Relevant catheterization findings.

1. 90% diffuse stenosis at left main trunk (LMT) from ostium to bifurcation
2. Diffuse long 90% stenosis from LAD#6 to LAD#7
3. 90% stenosis lesion at LCX#12 and LCX#13
4. CTO lesion at RCA#1 with good collateral vessels from LAD





[INTERVENTIONAL MANAGEMENT]

Procedural step. He was recommended CABG, but rejected. Thus we challenged PCI for the CTO and LMT lesion.

PCI strategy:

IABP was relative contra-indication due to the non-treated AAA.

If left coronary artery flow bacame slow during the PCI for LMT, his hemodynamics would be collapsed.

Thus, we tried to treat RCA#1 CTO lesion first.

PCI system for RCA#1 CTO:

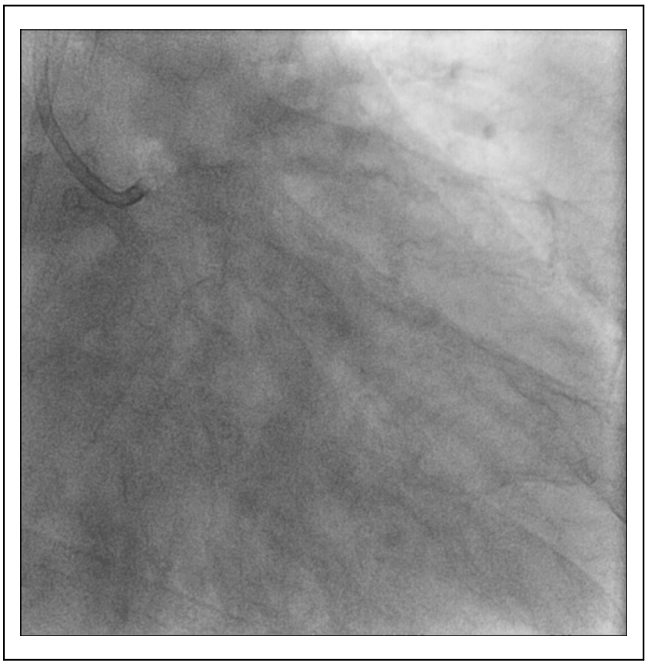
7F sheath from rt. femoral, Guiding Catheter (GC): AL 1 ST 7F (Brite-tip).

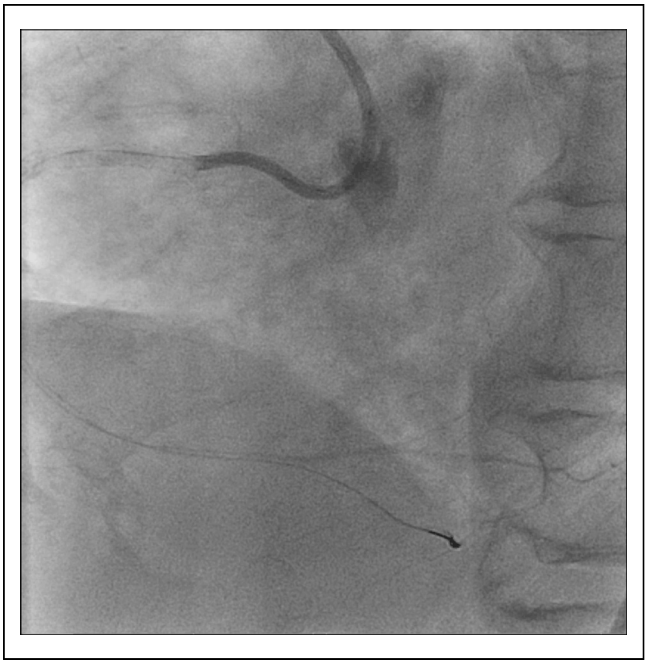
Antegradeapproach: Micro-Catheter (MC): Finecross GT, Guidewire (GW): X-treme XTR.

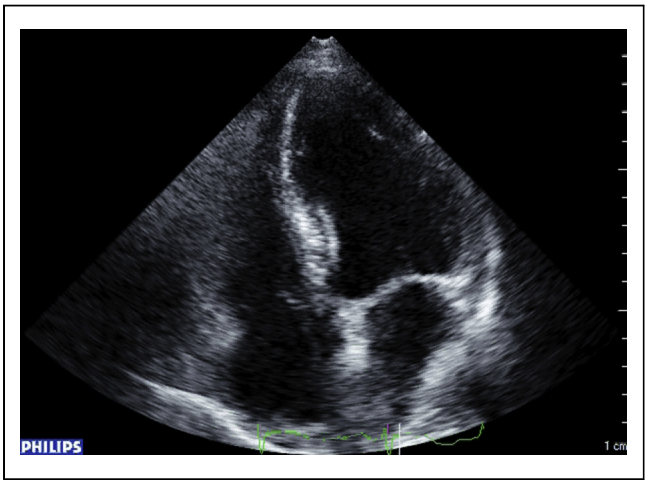
PCI system for LMT bifurcation:
GC:SL4.0 7F (Launcher), GW: Sion

1. First, Finecross GT and XTR successfully reached to RCA#4PD through the CTO lesion.
2. Sapphire2 1.0×6mm could pass CTO lesion by using anchor balloon technique with Trek 2.0x15mm at conus branch.
3. CTO lesion was dilated by the prescribed Trek 2.0×15mm.
4. Good dilatation and TIMI 3 flow were obtained after two Xience Xpedition.
5. Second, Xience Xpedition was successfully deployed from LMT ostium to proximal LAD and kissing balloon technique was performed with Powered Lacrosse2 2.5x15mm and Trek 2.0x15mm

His hemodynamics and left ventricular motion became normal after the PCI.
He could uneventfully discharge at 24 hospital day.







Case Summary. We experienced a challenging case of Killip4 NSTEMI patient with CTO and LMT lesion successfully treated by PCI.
Effective revascularization made the hospitalization shorter and his quality of life better.

TCTAP C-028
Bifurcation Left Main Stenting

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[CLINICAL INFORMATION]
Patient initials or identifier number. SB

Relevant clinical history and physical exam. Pt came with Acute chest pain in anterior leads with KILIP Class II failure and ST Elevation non diabetic hypertensive PTCA to Proximal LAD done 8 yrs ago.

Relevant test results prior to catheterization. Creatinine 1.0 2D Echo anterior wall hypokinases EF 40%

Relevant catheterization findings. There was distal LEFT Main lesion in the LAD and circumflex ostium around 90% with TIMI I flow in the LAD There was thrombous at the Ostiol proximal LAD the previous stent appear to patent, RCA non dominant normal.